STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	04/11/2017

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NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from April 4, 2017 through April 13, 2017. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 103. The Stage 2 survey sample size was 35. Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; RD - Registered Dietitian; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide; COTA - Certified Occupational Therapy Assistant; OT - Occupational Therapist; PT - Physical Therapist; UM - Unit Manager; SW - Social Worker; MD - Medical Doctor; FSD - Food Service Director; Anxiety- nervous, fearful; Auditory-hearing; Antipsychotic (medication)- used to treat psychosis and other mental / emotional conditions; Bruit and Thrill - Feeling/listening to resident's dialysis site for functioning; Braden scale-tool to evaluate risk of pressure sores; Catheterized - insertion of flexible tube to drain urine from the bladder; Cognitive - thinking;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/20/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Continence - control of bladder and bowel function; Contact precautions-reduce the spread of infection through direct contact from skin or infected objects with the use of mask, gown and gloves; Dementia-severe state of cognitive impairment; Diabetes Mellitus (DM) - disease where blood sugar levels are too high; Dialysis - cleansing of the blood by artificial means when kidneys have failed; e.g. - for example; EMR - Electronic Medical Record; Enoxaparin (Lovenox) - injected medication to prevent and treat blood clots; Fluid pill (i.e., Lasix) - medicine to reduce the amount of water/excess fluid in the body; Frequently Incontinent [urine] - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day period; Hallucinations - something that seems real but does not really exist; HTN-hypertension-high blood pressure; i.e.- that is; Incontinence - loss of bladder control and/or bowel function; Insulin - injected medication to treat Diabetes; Isolation-creates a barrier between people and germs used for infectious diseases or germs spread by touching patients and equipment; kg (Kilogram) - metric unit of weight, 1 kg equals 2.2 pounds lb (pound) - a unit of weight; 1 lb equals 16 ounces; MAR - Medication Administration Record: MDS - Minimum Data Set (standardized assessment forms used in nursing homes); mg (milligram) - unit of weight;	F 000		

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F 000	Continued From page 2 Medication Regimen Review - monthly review of medications by pharmacist; Neurogenic bladder - lack of bladder control due to brain, spinal cord, or nerve condition; OOB - Out of Bed; Pneumonia - lung infection; POS (Physician Order Sheet) - monthly report of active physician orders: PPD - skin test to check for tuberculosis; PPE (Personal Protective Equipment) - e.g., disposable gown, mask, gloves; Pressure Injury Wound (Pressure Ulcer) - sore area of skin that develops when blood supply to it is cut off due to pressure; PRN - when necessary; Psychotropic - medication capable of affecting the mind, emotions and behavior; Psychiatry - study and treatment of mental disorders; Paranoid-false belief that someone may hurt you; Psych (Psychological) - related to mental and emotional state of a person; Recapitulation (Recap) - monthly facility review of POS, MAR, TAR to ensure completeness and accuracy before the orders are signed by the resident's physician; Schizophrenia - mental disorder with false beliefs, confused thinking and bizarre thoughts; Stroke - a condition involving reduced blood supply to the brain from intracerebral hemorrhage, thrombosis, embolism, or vascular insufficiency; Standard precautions-reduce transmission of blood borne and other germs used in healthcare; TAR - Treatment Administration Record; TB-tuberculosis, lung infection; Thrombocytopenia - Disorder of the blood that causes bleeding, bruising, and slow blood clotting;	F 000		

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F 000	Continued From page 3 Tracheostomy (Trach) - tube in the neck for breathing; Urinary catheter - tube held in the bladder by a small balloon to drain urine; Urinary retention - unable to empty bladder completely.	F 000		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 167		5/26/17

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F 167	Continued From page 4 Based on observation and interview it was determined that the facility failed to have the results from certification surveys and complaint investigations from the preceding 3 years readily accessible to residents, family members and the public. The facility failed to ensure a posting notice with the location of the survey results was displayed in public view. Findings include: 4/4/17 at 9:30 AM - Observation during the initial tour found the following: - Survey binder did not contain the 2014 survey results. - Two surveys from 2016 (11/2/16 and 4/13/16) were both missing pages 1 and 2. - Signage explaining the location of the binder was found in a glass covered bulletin board outside the main dining room and it was hung so high that it was not readily visible to residents / visitors in wheelchairs. During an interview with E1 (NHA) on 4/4/17 at 10:30 AM, the issues with the survey binder were discussed and E1 stated the required additional surveys would be added and signage posted in an area visible to residents. These findings were reviewed with E1 and E2 (ADON) on 4/13/17 at 1:30 PM.	F 167	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both Federal and State laws. The survey binder has been updated to include the 2014 survey and the missing pages have been replaced. All upcoming surveys will be placed in the binder per policy. The survey binder will be checked by the Administrator/designee weekly times 4 weeks and monthly thereafter. The results of the weekly review of the survey binder will be discussed at the facility based QAPI meetings for the next three (3) months for additional recommendations and/or follow through.	
F 242 SS=E	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 242		5/26/17

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F 242	Continued From page 5 (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation it was determined that the practice at the facility was to schedule showers based on room number. The facility failed to allow one (R34) out of 35 sampled residents to make choices regarding shower schedule. Findings include: During an interview with R34 during stage 1 of the survey, when asked "Do you choose how many times a week you take a bath or shower?" the resident responded "No, in the other room it was Tuesday and Friday, now in this room, I am not sure when they are." The resident had moved to a different room on the same unit within the past two days. 2/18/16 - Resident Profile (no revision date) documented that R34 needed the assistance of 1 staff person for bathing. Shower per schedule and as needed. 4/6/17 - Review of facility document entitled North Side Shower Schedule discovered six days of the week written across the top (Monday through Saturday) and room numbers written below each day of the week...with half the rooms listed under day shift and half under evening shift. Showers	F 242	Resident R34 continues to reside in the facility and her shower days have been updated based on her personal preference. A full house audit will be completed by the interdisciplinary team to ensure resident showers are scheduled based on the resident's preference. The facility policy for scheduling showers will be updated to state that resident showers will be scheduled on admission by resident preference. The nursing staff will be educated by the Staff Development Coordinator/designee on the policy update. Ten(10) residents will be interviewed weekly for four (4) weeks by Social Services and/or designee regarding resident shower preferences then monthly times two (2) months. The results of the audit regarding resident preferences for showers will be discussed at the facility based QAPI meetings for the next three (3) months for additional	

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F 242	Continued From page 6 were scheduled by room number in this facility. During an interview with E4 (UM) on 4/7/17 at 11:45 AM, when asked if a resident changes rooms, does the shower schedule change, E4 said "Yes, it is based on their room." This finding was reviewed with E1 (NHA) and E2 (ADON) on 4/13/17 at 1:30 PM.	F 242	recommendations and/or follow through.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 272		5/26/17

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F 272	Continued From page 7 (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to make an accurate comprehensive assessment by not including all diagnoses and behaviors for one (R177) out of 35 sampled residents. Findings include: Review of R177's clinical record revealed: 12/22/16 - Admission to the facility after hospitalization with multiple diagnoses including schizophrenia. 12/23/17 - Care plan included a problem for psychosocial issues related to auditory hallucinations, paranoia and increased anxiety when hallucinating.	F 272	Resident R177 has been discharged. An audit of all current resident MDS's and diagnosis list will be completed to ensure that appropriate diagnoses are captured on the MDS. The Clinical Reimbursement Team will complete the diagnosis list for new admissions to ensure all diagnosis are captured and included on the MDS. A weekly audit of five (5) MDS's will be completed by the Clinical Reimbursement Director times four (4) weeks then monthly times two (2) to ensure appropriate diagnoses have been coded.	

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F 272	Continued From page 8 Nursing progress notes documented signs of hallucinations: 12/27/16 (4:10 PM): "Resident noted to be talking to himself laughing" 12/28/16 (1:50 PM): "Hallucinating" 12/29/16 (3:50 PM): "Continued to be hallucinating" 12/29/16 - Admission MDS Assessment did not include the diagnosis of schizophrenia or hallucinations. During an interview with E16 (LPN) on 4/12/17 at 2:40 PM to review the diagnoses and behavior sections of the MDS assessment E16 confirmed schizophrenia was written on her working copy but it did not get entered in the computerized MDS Assessment. The surveyor informed E16 that hallucinations were documented in the nursing notes beginning 12/27/17, two days before the MDS Assessment. E16 added that s/he would look into the hallucinations since someone else completed that section of the assessment and complete a correction as needed. These findings were reviewed with E1 (NHA) and E2 (ADON) on 4/13/17 at 1:30 PM.	F 272	The results of the audit regarding MDS coding for diagnoses will be discussed at the facility based QAPI meetings for the next three (3) months for additional recommendations and /or follow through.	
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of	F 282		5/26/17

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F 282	Continued From page 9 care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to provide services based on the plan of care for one (R99) out of 35 sampled residents by not raising heels off the bed during multiple surveyor observations. Findings include: Review of R99's clinical record revealed the following; 12/17/16 - A quarterly Braden Scale assessment, scored R99 at a 13, high (high risk for pressure ulcer development) is 0-13. R99's care plan for risk for pressure ulcer development, last updated 2/2/17, with the goal of preventing pressure ulcers from developing included the intervention to float heels (raise the heels to avoid direct contact with the mattress while in bed). 3/13/17- An annual MDS assessment identified R99 was at risk for pressure ulcers. During an observation on 4/4/17 at 12:12 PM R99 was seen with heels resting on a pillow, not floated above the bed. During an observation on 4/5/17 at 11:15 AM R99 was seen with heels directly on the bed, not floating, heels appeared to be reddened. During an observation on 4/5/17 at 1:31 PM R99 was seen in bed on back with heels directly on the bed.	F 282	Resident R99 continues to reside in the facility. She has been assessed by the Rehab Department and the appropriate interventions will be put in place to protect the heel. The resident's care plan and care delivery guide will be updated to reflect the new interventions. Residents identified with at risk for pressure ulcer care plans in place, will have their interventions reviewed by the Interdisciplinary Team for appropriateness. Nursing staff will be educated by Staff Development and/or designee regarding following resident interventions for pressure ulcer prevention. A random audit of five (5) residents requiring pressure ulcer interventions will be completed by the Director of Nursing and/or designee weekly for four (4) weeks then monthly times (2) months to ensure interventions that are care planned are being implemented by staff. The results of the audit regarding care plans with appropriate wound care interventions will be discussed at the facility based QAPI meetings for the next three (3) months for additional recommendations and/or follow through.	

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F 282	Continued From page 10 During an observation on 4/5/17 at 2:29 PM R99 was seen in bed on back with heels directly on the bed. During an observation on 4/10/17 at 12:25 PM R99 was seen in bed with pillows under both legs however, heels were in contact with the bed. During an observation on 4/10/17 at 1:56 PM R99 was seen in bed with pillows under both legs however, heels were in contact with the bed. During an interview and observation of R99 on 4/10/17 at 2:25 PM with E12 (CNA) R99 was observed with heels directly touching the bed. When asked if R99's heels were positioned properly, E12 responded "Yes, fine if you ask me." When asked if R99's heels were floated, E12 stated "They are ok." E12 then pulled R99 up in bed and repositioned the pillow under R99's both lower legs. During an interview and observation of R99 on 4/10/17 at 2:40 PM with E11 (LPN) it was confirmed that R99's heels were not positioned properly because they were not floated above the bed. E11 stated "Her heels, they are not offloaded. They should be floating." E9 then repositioned the pillow so R99's heels were floating. R99 was assessed as high risk for pressure ulcers and had a care plan for risk of pressure ulcer that included the intervention to float her heels. There were 8 observations over the course of three days, 4/4/17, 4/5/17 and 4/10/17 where R99's heels were seen directly on the bed. The facility failed to provide offloading of pressure to R99s heels by floating them as directed in her	F 282		

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F 282	Continued From page 11 risk for pressure ulcer care plan. These findings were reviewed with E1 (NHA) and E2 (ADON) on 4/13/17 at 1:30 PM.	F 282		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	F 309		5/26/17

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F 309	Continued From page 12 of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that four (R184, R185, R186 and R187) of 35 sampled residents received the necessary care and services to attain or maintain the highest practicable physical well-being, consistent with the resident's comprehensive assessment and plan of care. R184, R185 and R186 did not have weights completed as ordered. In addition, the facility failed to ensure that R187's physician's orders for medication administration were implemented as ordered resulting in the administration of four doses of a blood thinner after the medication was discontinued. Findings include: 1. Review of R187's clinical record revealed the following: 3/28/17 - Admitted to the facility from being hospitalized for a stroke and developing thrombocytopenia, low levels of blood clotting factors that increased the risk for bleeding. 3/28/17 - Admission physicians' orders included: Enoxaparin (a blood thinner) to be injected once a day to prevent blood clots. 3/29/17 - Physicians' orders discontinued the Enoxaparin. March 2017 MAR revealed R187 did not receive any Enoxaparin that month.	F 309	Resident 187 continues to resident in the facility. The attending physician was notified of the med error. The resident did not suffer any ill effects from the med error. Resident R185 has been discharged. Residents R184 and R186 continue to reside in the facility and have not experienced any negative outcomes. They will be weighed by three (3) days to ensure their weights are stable. The results will be reviewed by the dietician for any necessary recommendations. Residents with current orders for daily weights will be placed on the 24 hour report until completion. The dietician will monitor weight orders for completion. The Unit Managers and/or designee will check orders received the last 7 days of the month to ensure orders are carried over during change over. Licensed nursing staff will be in-service by Staff Development and/or designee regarding the current weight policy and change over procedure. A random audit of ten (10) Medication Administration Records will be completed at the beginning of the month times three (3) months by the Director of Nursing and/or designee.	

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F 309	Continued From page 13 April 2017 MAR documented that R187 was given Enoxaparin on April 1, 2, 3 and 4, placing the resident even at a higher risk for bleeding. During an interview on 4/5/17 at 1:00 PM, after the surveyor identified this medication error, E3 (UM) confirmed that R187 should not have received the four doses of the blood thinner in April and that there was a transcription error when the April MAR was written. E3 stated s/he would notify the attending physician (E9) and discontinue the Enoxaparin on the April MAR, which s/he did. During an interview on 4/5/17 at 2:45 PM, E2 (ADON) was notified of above medication error, reviewed facility documentation and confirmed this error. 2. Review of R184's clinical record revealed the following: 4/3/17 - Admitted to the facility after hospitalization for a kidney injury. 4/3/17 - Admission physicians' orders included: weigh daily for 3 days. During an interview with E5 (RD) on 4/6/17 at 10:20 AM, the surveyor explained inability to locate R184's daily weights. E5 stated that on the facility's admission data collection form, dated 4/3/17, a nurse documented that R184 weighed 78.4 lbs. Surveyor pointed out that R184 did not appear to weigh only 78.4 lbs, and that this facility weight conflicted with hospital documentation of 66 kg (145 lbs). E5 acknowledged this and stated s/he would follow up. Weights should have been done on 4/4/17, 4/5/17 and 4/6/17.	F 309	An audit of new admission weight orders will be completed by the Dietician and/or designee times four (4) weeks then monthly times (3) months. The results of the audit regarding weights and medications will be discussed at the facility based QAPI meetings for the next three (3) months for additional recommendations and/or follow through.	

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F 309	Continued From page 14 During an interview on 4/13/17 at 10:15 AM, E5 stated the 4/5/17 weight (105 pounds) was found with the April monthly weights. E5 stated s/he actually weighed R184 personally (after being asked for weights by the surveyor) on 4/6/17 and the resident weighed 129 lbs. In addition, E5 reported that on 4/10/17 R184 weighed 131 lbs. E5 was unable to explain the earlier discrepancies, but felt the last two weights (4/6/17 and 4/10/17) were accurate. E5 confirmed there was no weight for 4/4/17. 3. Review of R185's clinical record revealed the following: 3/27/17 - Admitted to the facility after hospitalization for pneumonia and throat cancer. 3/27/17 - Physician's admission orders included: weigh daily for 3 days. During an interview with E5 (RD) on 4/6/17 at 10:20 AM, E5 confirmed s/he was only able to find R185's admission weight of 113 lbs on 3/27/17 and a weight of 115 lbs on 4/2/17. E5 was not able to find documentation of weights from 3/28/17, 3/29/17 or 3/30/17. 4. Review of R186's clinical record revealed the following: 4/2/17 - Admitted to the facility from the hospital with a feeding tube. 4/2/17 - Admission physicians' orders included: weigh daily for 3 days. During an interview with E5 (RD) on 4/6/17 at	F 309		

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F 309	Continued From page 15 10:20 AM, E5 confirmed s/he was only able to find R186's admission weight of 158 lbs on 4/2/17. E5 was not able to find documentation of any weights for 4/3/17, 4/4/17 or 4/5/17. These findings were reviewed with E1 (NHA) and E2 (ADON) on 4/13/17 at 1:30 PM.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one (R160) out of 35 sampled residents the facility failed to ensure a wound treatment was conducted in a manner that prevented infection. Findings include: Review of an untitled, undated policy provided by the facility to address wound dressing changes included the approaches "set up tray with what	F 314	Resident R160 continues to reside in the facility and has experienced no negative outcomes. Employee E10 has been in-serviced by the Staff Development Coordinator regarding appropriate treatment protocol. Licensed nurses have been observed during their treatment process by the	5/26/17

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F 314	Continued From page 16 you need before entering the room" and "wash your hands after handling the patient." The following was observed during a treatment to R160's pressure ulcer on 4/7/17 starting at 11:42 AM: E10 (LPN) entered R160's room with the surveyor, treatment supplies were sitting on a cushioned chair near the end of the bed with no barrier or tray. E10 put on gloves, no handwashing was observed. E10 then picked up the remote to the bed and lowered the bed, repositioned the resident in bed, placed a towel under the resident and removed the old dressing. E10 then changed gloves without hand hygiene after having contaminated herself with the remote and resident linens. During the treatment E10 did not have supplies needed opened on a clean field resulting in her having to open packaging during the treatment potentially re-contaminating her hands including using scissors that were laying on the chair to cut the dressing that would be placed in the wound bed. When the treatment was completed E10 collected all her supplies and put them in the treatment cart out in the hall before performing hand hygiene. On 4/7/17 at 2:37 PM a review of the treatment technique was conducted with E10. During an interview with E1 (NHA) on 4/11/17 at 11:30 PM the surveyor reviewed the observed issues with infection control technique during the dressing change.	F 314	Director of Nursing in order to educate on infection control process. Licensed nursing staff will be in-serviced by the Staff Development Coordinator and/or designee on infection control procedures during treatments. Random observations of three (3) treatments will be completed weekly times four (4) weeks, then monthly times two (2) by the Staff Development Coordinator and/or designee to observe and educate nursing staff on infection control processes. The results of the audit regarding infection control procedures during treatments will be discussed at the facility based QAPI meetings for the next three (3) months for additional recommendations and/or follow through.	
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		5/26/17

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F 315	Continued From page 17 (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed	F 315	Resident R85 continues to reside in the facility with no negative outcomes. Her	

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F 315	Continued From page 18 to provide incontinence care according to the plan of care for one (R85) out of 35 sampled residents. Findings include: Review of R85's clinical record revealed: 4/12/16 - Care plan problem for incontinence (last reviewed 9/8/16) included the following interventions: Check for incontinence upon rising, before and after meal times, at bed time and as needed during care; Toilet resident as needed (added 5/25/16). 6/4/16 - Resident Profile documented that R85 needed the assist of 1 staff for transfer, toileting and dressing. The resident was incontinent of the bladder most of the time. 2/13/17 - Quarterly MDS Assessment documented R85 was frequently incontinent of bladder and was always incontinent of bowel. The resident was not on a toileting program and required extensive assistance with transfer, dressing, toileting, and personal hygiene since balance was not steady and could stabilize only with human assistance. 4/5/17 (11:15 AM - 12:15 PM) - R85 observed in the activity room seated in a wheelchair attending an activity of coloring butterflies. When kneeling next to the resident the surveyor smelled a strong odor of urine. Continual observation found R85 propelled self in the wheelchair to the hallway outside the dining room and waited there until the dining room doors were opened. R85 entered the dining room and ate lunch without incontinent care being provided. 4/5/17 (2:35 PM) - Resident noted to be in	F 315	wheelchair has been cleaned and the sheelchair cushion has been replaced. Current residents identified as being incontinent have been reviewed and monitored by the Unit Managers to ensure appropriate interventions are being implemented to ensure timely care and treatment has occurred. Nursing staff will be educated by the Staff Development Coordinator and/or designee regarding the appropriate care and timely services for the resident, as indicated in the plan of care. Random audit of those residents' identified as being incontinent will be completed by the Unit Managers and/or designee to ensure residents are receiving timely care throughout the day. The results of the audit regarding lack of incontinent care according to the resident's plan of care will be discussed at the facility based QAPI meetings for the next three (3) months for additional recommendations and/or follow through.	

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F 315	Continued From page 19 different clothing after incontinent care while attending an afternoon activity in the activity room. When leaning down next to the resident the surveyor noted a light odor of urine remained. 4/7/17 (11:20 AM - 12:25 PM) - Observation of R85 seated in wheelchair outside activity room. When leaning down next to the resident the surveyor noted the odor of urine. R85 was taken into the dining room for lunch without incontinent care. 4/7/17 (12:40 PM) - Surveyor informed E17 (CNA) that the surveyor wanted to observe the next incontinent care. Resident was still eating in the assisted section of the dining room at that time. 4/7/17 (2:25 PM) - E17 informed the surveyor that R85 already had incontinent care completed. The CNA said "I could not find you." Resident was wearing different clothing and when the surveyor sat next to R85 in the lounge area, the surveyor noted a slight urine odor. It was unclear if the odor was from the resident or the wheelchair. 4/10/17 (9:30 AM - 12:15 PM) - R85 participated in activities, first in the lounge area then moved into the activity room. At 11:30 AM R85 wheeled self up the hallway and sat outside the dining room. The surveyor stooped down to talk with the resident and noted a strong odor of urine. R85 entered the dining room at 12:15 PM for lunch without receiving incontinence care. 4/10/17 (12:40 PM) - Surveyor informed E17 again about the need to observe incontinent care	F 315		

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F 315	Continued From page 20 [to determine how much of the urine odor was from the resident versus the wheelchair]. E17 expressed understanding. 4/10/17 (1:45 PM - 2:00 PM) - Prior to incontinent care surveyor asked how often incontinent care was done on the day shift? E17 responded 2 to 3 times but "sometimes I get so busy or someone [another CNA] calls out" and it does not get done. "I try to get to her before lunch." While R85 was seated on the toilet the wheelchair was observed to have wetness on the wheelchair cushion. E17 wiped dry paper towels on the wheelchair cushion to dry the moisture. No cleaning solution or disinfectant wipes were used. The surveyor noted and stated that the wheelchair / cushion had a urine smell. During an interview with E2 (ADON) on 4/10/17 at 2:30 PM the surveyor described observations of the urine smell prior to lunch on three occasions and the lack of incontinent care according to the residents plan of care. When asked about the cleaning of wheelchairs / cushions, E2 said that housekeeping cleans them. These findings were reviewed with E1 (NHA) and E2 on 4/13/17 at 1:30 PM.	F 315		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must	F 425		5/26/17

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F 425	Continued From page 21 employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R160) out of 35 sampled residents the facility failed to ensure medication was available from the pharmacy for administration. The facility also failed to have a policy that addressed the use of the Back Up (medication) Box. Findings include: The facility provided the policy Emergency Medication Supplies (last revised 1/1/13) in response to a request for a policy addressing the Back Up (medication) Box which contained different medications than the Emergency Box also located in the facility. Review of R160's March 2017 MAR documented the following: - Catapres 0.1 mg [medication for high blood pressure] twice a day for HTN was circled on March 1, 2 and 3 indicating it was not administered. - Lasix 40 mg (fluid pill) once a day for HTN was circled as not administered on 3/2/17. - The back of the MAR documented the reason the medications were not given as they were re-ordered. Review of the Back Up Box medication list provided by the facility revealed that both medications were in the box and were available to R160 while awaiting for the re-order to arrive.	F 425	Resident R160 continues to reside in the facility and has experienced no negative outcomes. His attending physician was notified of the missed medications with no further orders. An audit will be completed by the Unit Mangers and/or designee ensuring current residents are receiving their medications timely as ordered. Licensed nursing staff will be educated by the Staff Development Coordinator and or designee regarding the contents and utilization of the backup box for those medications that are unavailable in the medication cart and waiting to be sent from Pharmacy. Random audits will be completed by the Unit Managers weekly times four (4) weeks then bi-weekly times four (4) weeks ensuring residents are receiving medications timely and that the backup box for medication is being used appropriately as needed. The results of the audit regarding the utilization of the backup box for unavailable medication will be discussed at the facility based QAPI meetings for the next three (3) months for additional	

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F 425	Continued From page 22 An interview on 4/12/17 at 1:33 PM with E4 (UM) revealed the location and contents of the Back Up Box and E4 stated that the box would be used if the resident was out of medication. This finding was reveiwed with E1 (NHA) and E2 (ADON) on 4/13/17 at 1:30 PM.	F 425	recommendations and/or follow through.	
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 428		5/26/17

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F 428	Continued From page 23 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of pharmacy documentation it was determined that the facility failed to ensure the physician reviewed irregularities discovered by the pharmacist during the monthly medication regimen reviews for three (R160, R147 and R56) out of 35 sampled residents. Findings include: 1. The following was reviewed in R160's clinical record: 9/1/16 - Pharmacy Consultation Report documented that there were no specified parameters for when the provider (doctor) would be notified of abnormally high or abnormally low blood sugar values. There was no evidence that	F 428	Residents R160, R147, and R56 continue to reside in the facility with no negative outcomes. The Pharmacy Consultant was immediately called to forward missing recommendations to the Director of Nursing for follow up. An audit has been completed by the Unit Managers and/or designee to ensure residents receiving medications from the Pharmacy have a Pharmacy Consultant report available for review and appropriate physician and nursing follow through. Licensed nursing staff will be educated by the Staff Development Coordinator and/or	

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F 428	Continued From page 24 the physician acknowledged this recommendation. 9/1/16 - Pharmacy Consultation Report provided the physician with the Federal requirements for using antipsychotic medications with a recommendation to provide the specific diagnosis and symptom / behavior for continued use. There was no evidence that the physician acknowledged this recommendation. 1/3/17 - Pharmacy Consultation Report requesting a laboratory test monitoring for Diabetes. There was no evidence that the physician acknowledged this recommendation. 4/10/17 - Pharmacy Consultation Report "repeated recommendation" from 1/3/17. The Medication Regimen Review sheet from March 2016 through February 2017 was missing from the clinical record. On the Medication Regimen Review from March 2017 the pharmacist wrote that the previous sheet could not be located by staff on 4/11/17 and 4/12/17. The document was not located until 4/13/17. An interview on 4/12/17 at 3:04 PM with E2 (ADON) provided the surveyor with copies of the above Pharmacy Consultation Reports that were obtained from the pharmacy since they were not available in R160's clinical record. E2 confirmed there was no evidence that the MD reviewed any of these recommendations. 2. Review of R147's clinical record revealed the following; Medication reviews conducted on 1/24/17 and	F 428	designee regarding the monthly review of Pharmacy Consultation Reports to ensure recommendation are addressed timely. Random audits will be completed weekly times four (4) then monthly times four (4) by the Unit Manager and/or designee to ensure Pharmacy Consult Reports are available and have been addressed by physician and nursing. The results of the audits regarding availability and review of the Pharmacy Consultation Report will be discussed at the facility based QAPI meetings for the next three (3) months for additional recommendations and/or follow through.	

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F 428	Continued From page 25 2/21/17 both had the box for a report of suggestions, irregularities or recommendations by the pharmacist checked. However R147's chart did not contain the corresponding Pharmacy Consultation Report. During an interview with E2 (ADON) on 4/11/17 at 2:54 PM with E2 confirmed that the facility was unable to provide evidence of the Pharmacy Consultation Reports from 1/24/17 and 2/21/17 and whether the MD reviewed them. 3. Review of R56's clinical record revealed the following; Medication reviews conducted on 1/3/17 and 3/1/17 both resulted in recommendations for an assessment to be completed for the monitoring of involuntary movements, a side effect antipsychotic medications. The recommendation made on 1/3/17 was not acted upon since the assessment was not completed until 4/3/17. These findings were reviewed with E1 (NHA) and E2 on 4/13/17 at 1:30 PM.	F 428		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431		5/26/17

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F 431	Continued From page 26 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431		

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F 431	Continued From page 27 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one out of two nursing units the facility failed to properly label medicaton and failed to ensure that controlled medications were accounted for on every shift. Findings include: 1. Review of the 500 hall medication cart on 4/4/16 at 10:40 AM found two bottles of short-acting insulin that were open and in use for residents lacked an open date. Insulin is good for 28 days after opening according to the manufacturer. 2. Review of the Shift Verification of Controlled Substances Sheets on medication cart 500 from March, 2017 noted that 23 out of 93 shifts were not signed by the on-going and/ or off-going nurse indicating the quantities of controlled substances matched. During an interview on 4/4/17 at 10:46 AM with E13 (LPN) it was confirmed that the insulin bottles did not have an open date and were removed from use and that there were numerous blanks on the Controlled Substance Sheet. Findings were reviewed with E1 (NHA) and E2 (ADON) on 4/13/17 at 1:30 PM.	F 431	Medication rooms and mediation carts have been inspected for any medication that had expired shelf life and/or were not properly dated when opened were discarded immediately. Licensed nursing staff will be educated by the Staff Development Coordinator and/or designee regarding the inspection of medications stored in the medication room and medication carts to identify and medications that have expired or have not been dated when opened. Licensed staff will be educated on proper technique on dating vials and liquids upon opening. Audits will be completed by the Unit Mangers and/or designee weekly times four (4) weeks then monthly times four (4) weeks inspecting the medication rooms and carts to identify any outdated and/or undated medications. Any identified medication will be discarded immediately. The results of the audits regarding outdated medications will be discussed at the facility based QAPI meetings for the next three (3) months for additional recommendations and/or follow through.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		5/26/17

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F 441	Continued From page 28 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 441		

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F 441	Continued From page 29 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documentation it was determined that the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of disease and infection. The facility failed to investigate and analyze infections and to determine trends and if any corrective actions were warranted to control and prevent infections in the facility. The facility failed to ensure appropriate tuberculosis (TB) testing was completed for two (R182 and R142) out of 35 sampled residents. The facility failed to	F 441	The infection Control Manual has been updated to include current guidelines and forms. Residents R142, R181, and R182 no longer resides in the facility. Resident R25 continues to reside in the facility and continues to require contact isolation and has had the appropriate PPE provided and care plan and care delivery guide has been updated. Those residents admitted with the last 30 days will be audited by the Unit Managers and/or designee to ensure that they have	

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F 441	Continued From page 30 implement isolation precautions and provide PPE for two (R25 and R181) out of 35 sampled residents. Findings include: Infection Control Program 1. Review of the Infection Control Manual (dated 2013) found outdated immunization guidelines from 2009. The facility Immunization form in the manual was also outdated as a new one (dated 2014) was in use in the clinical records. During an interview with E18 (RN, Infection Control Practitioner / Staff Development) on 4/7/17 around 2:00 PM E18 stated s/he took over infection control the end of February, 2017 and began surveillance in March 2017. E18 did not think that the data prior to that time was complete. It took the facility over 24 hours to provide the surveyor with the Monthly Line Listing Report, Monthly Incidence Rates and Report of Possible or Known Infection or Communicable Disease from 2016. 4/10/17 - Review of the monthly facility forms entitled Monthly Line Listing Report, Monthly Incidence Rates and Report of Possible or Known Infection or Communicable Disease from June 2016 through and March 2017 provided over 24 hours after request (January and February 2017 not made available for review) discovered the lack of analysis due to the inconsistent completion of: - Investigation/analysis section to be done by the infection control practitioner. - Site of infection for eyes, ears (e.g. right eye, left ear) and wounds. - Whether or not a culture was obtained to	F 441	a 2-step PPD completed and documented. Those residents with identified infections will be audited by the Unit Managers and/or designee to ensure that PPE is readily available and care plans and care delivery guides have been updated. The Staff Development Coordinator and Director of Nursing will be educated on the tracking and trending of infections by the Regional Nurse Consultant. The Staff Development Coordinator will provide in-service to licensed nursing staff regarding the requirement of obtaining 2-step PPDs on all new admissions. The Regional Nurse Consultant along with the Director of Nursing will review the line listings weekly times four (4) then monthly thereafter to identify trends in the facility. Audits will be completed by the Unit Managers and/or designee weekly times four (4) then monthly times four (4) on new admissions to ensure 2 step PPDs have been completed as part of the admission process. The Central Supply Coordinator will audit the personal protective equipment supply weekly to ensure there is an adequate supply of protective equipment supply. The results of the audits regarding infection control will be discussed at the facility based QAPI meeting for the next three (3) months for additional recommendations and/or follow through.	

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F 441	Continued From page 31 determine the type of infection. - Organism (type of infection). - Name of antibiotic or treatment. - Infection classification (occurred in facility or community). - Monthly incidence rate with comparison to previous month (most months without any totals). During an interview with E1 (NHA) on 4/12/17 at 3:40 PM to discuss the infection control program findings, E1 confirmed the 2009 immunization guidelines were in the manual and said they would get updated. Surveyor reviewed the lack of analysis and E1 offered no explanation. Tuberculosis (TB) Skin Testing 2. Review of R182's clinical record revealed: 2/15/17 - Admission physicians' orders included 2-step PPD (tuberculosis skin testing). February 2017 - R182's MAR documented the resident received the first of the two skin tests on 2/15/17 (was read as negative on 2/18/17). The second skin test was scheduled for 2/25/17, but had no nurse initials indicating it was done. The nurse circled his/her initials on 2/28/17 reflecting the reading of the skin test was not completed. The handwritten comment on the back of the MAR included "PPD N/A" (skin test was not applicable - not done). 3. Review of R142's Tuberculosis Screening Record revealed: Handwritten entry dated 2/28/27 stated "PPD was not given on 2/25/17." There was no evidence in the record that the TB skin test was administered at that time. The	F 441		

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F 441	Continued From page 32 second skin test could have still been done on 2/28/17. During an interview with E18 (RN, Infection Control) on 4/7/17 around 2:00 PM to review the missing TB skin test E18 confirmed the missing test and retained the clinical record to determine which nurse did not administer the second skin test to provide education. Review of R142's clinical record revealed: 1/25/17 - Admission physicians' orders included 2-step PPD. January - February 2017 - R142's MAR's documented the resident received the first of the two TB skin tests on 1/25/17 and was to be read on 1/28/17. The entry under 1/28/17 was blank, no result was documented. Review of nursing progress notes did not find evidence of the result of the TB skin test. The second TB skin test was completed and was negative. During an interview with E18 (RN, Infection Control) on 4/7/17 around 2:00 PM to review the missing skin test result E18 confirmed the first step result was not in the record and retained the clinical record to determine which nurse did not record the result of the first TB skin test to provide education. Isolation Precautions 4. Review of R25's clinical record revealed: 4/3/17 - R25's care plan problem for anti-infective had the goal to prevent the spread of infection and included the intervention of contact precautions.	F 441		

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F 441	Continued From page 33 4/10/17 - At 3:16 PM a visiting family member of R25 requested a surveyor to come to the resident's room to observe that there was no PPE readily available to staff performing care. E8 (LPN) was in front of R25's room wearing a mask but no other PPE . E8 confirmed that disposable, one-time use isolation gowns were not available and reported that she had notified the supply staff that morning when she used the last isolation gown avaialble on the table outside of the room. E8 confirmed that she was about to provide care for R25 without the required PPE, wearing only a mask and no gown. 4/11/17 at 9:10 AM a list of residents on isolation precautions was provided by E2 (ADON) and documented R25 as on contact/droplet precautions. E2 then confirmed that required PPE for R25's isolation precautions was a gown, mask, and gloves. 5. Review of R181's clinical record revealed: 3/8/17 - Resident admitted to facility with a drug resistant bacteria pneumonia (lung infection) that was being treated with antibiotics. 3/8/17 - Review of the Care Plan and Communication Tool used by direct care staff to determine care needed revealed that the resident was on "standard precautions" and did not mention isolation precautions. 3/17/17 - Care plan problem for anti-infective stated that the resident had a drug resistant bacteria in the tracheostomy and was on contact precautions. There were no approaches as to what personal protective equipment (PPE) would	F 441		

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F 441	Continued From page 34 need to be used when providing care or when the resident was out of the room. 3/25/17 - Repeat lab culture showed the resident still had drug resistant bacteria. April 2017 - Physician order sheet with no mention of isolation precautions. 4/12/17 - Resident's room had isolation PPE and a sign on the door to "See nurse before entering room." During an interview with E3 (UM) on 4/12/17 at 11:53 AM E3 revealed that staff should wear a mask when entering the room and should use a gown and gloves when providing care. When the resident is out of the room s/he would wear a mask over the trach. During an interview with E14 (CNA) on 4/13/17 at 10:50 AM (CNA) that s/he was not familiar with the resident but would ask the nurse or check the Care Plan and Communication Tool to see what precautions to take. During an interview with E15 (CNA) who was assigned to R181 on 4/13/17 at 10:50 AM E15 (CNA) revealed s/he would ask the nurse or check the Care Plan and Communication Tool to see what precautions to take. S/he stated that for R181 a mask, gown and apron is used in room and the resident wears a mask when out of the room. E15 stated s/he thought the infection was on the neck. Two staff interviewed stated that they would use the facilities communication tool to know what type of isolation precautions to take if the nurse	F 441		

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F 441	Continued From page 35 was not available. R181's communication tool did not have the correct isolation information. These findings were reviewed with E1 [NHA] and E2 on 4/13/17 at 1:30 PM.	F 441		
F 463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview it has been determined that the facility failed to ensure there was a functioning call system in 3 [403, 508, 303] out of 35 rooms reviewed. Findings include: Observations were made during stage 1 (between 4/4/17 (9:00 AM) and 4/6/17 (12:00 PM) and on 4/7/17 (between 10:40 AM and 11:25 AM): - Rooms 403 and 508: the call bell cord in the bathroom wrapped around the grab bar so that the call bell did not function when the cord was pulled from below the bar. - Room 303: call bell button was missing from the call bell apparatus. Additional observations of this finding were made at 1:15 PM and 2:30 PM on 4/7/17. During an interview and tour with E2 (ADON) on 4/7/17 at 3:00 PM, E2 confirmed this	F 463	Rooms 303,403, and 508 have had the call bells replaced. An audit was completed by the Maintenance Director of all rooms to further identify any broken or missing call bell apparatus. Facility staff has been educated by Staff Development Coordinator and/or designee on reporting to maintenance any call bell apparatus that needs repair or replacement. Call bells will be placed on a preventive maintenance program. Random audits will completed by the interdisciplinary team weekly times for (4)	5/26/17

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F 463	Continued From page 36 finding and immediately started the process for the repair of the call bell. These findings were reviewed with E1 (NHA) and E2 on 4/13/17 at 1:30 PM.	F 463	weeks then monthly times (4) weeks to inspect call bells and report to maintenance to be replaced. The results of the audits regarding broken and/or missing call bell apparatus will be discussed at the facility based QAPI meetings for the next three (3) months for additional recommendations and/or follow through.	
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 514		5/26/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 37 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to maintain medical records in a manner that ensured they were complete, accurate, readily accessible and systematically organized for 9 [R160, R61, R78, R112, R147, R19, R43, R177, R184] out of 35 residents sampled. Findings include: 1. During stage 1 of the survey on 4/4/17 and 4/5/17 resident weights were not easily accessible. For the 30 admission records reviewed, weights were not found in the clinical records. The dietician had to provide weights for everyone on the list from RD records. It was not a process at the facility to transcribe the weights from the facility weight lists into the clinical record. Weights for the 40 census records reviewed had to be searched for using various documents that listed residents by room number on each of the six units, not by name. If the resident had a room change while in the facility weights became even more difficult to obtain. 2. Throughout the survey for all residents reviewed the facility took considerable time finding POS's, MARS and TAR's. Filing was not up to date and documents were in piles at the	F 514	Weight record sheets have been added to tall clinical records. Three (3) months of POS, MARs, and TARs have been added to the clinical records. March and April Pharmacy Consultation Reports have been placed in the clinical records. Resident R61 and R177 no longer resides in the facility. Resident R78 continues to reside in the facility with no negative outcome. The resident's TAR was updated to include monitoring of the bruit and thrill. Resident R112 and R147 continues to reside in the facility with no negative outcome. A new pain assessment has been completed identifying their pain intensity goal. Resident R19 continues to reside in the facility with no negative outcome. A new Activity care lan has been developed for the resident. Resident R184 continues to remain in the facility with no negative outcome. She will be weighed time three (3) days to ensure their weights are stable. The results will be reviewed by the dietician for any necessary recommendations.	

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	085039	A. BUILDING _____ B. WING _____	04/11/2017

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F 514	Continued From page 38 nurses' station and in offices. 3. The MDS and CNA documentation for all residents in the sample was stored in an electronic system that the surveyors did not have access. Surveyors had to ask staff to print these documents when needing to review. 4. Cross refer F428, Example #1 R160's Medication Regimen Review sheet for 3/2016 through 2/2017 was missing from the clinical record. The Medication Regimen Review for 3/2017 documented by the pharmacist that the previous sheet could not be located by staff on 4/11/17 and 4/12/17. The document was not located until 4/13/17. The Pharmacy Consultation Reports were obtained from the pharmacy and were not available in the resident's clinical record. 5. The following was reviewed in R61's clinical record: Undated - Report sheet documenting phone call from the hospital before admission noted that R61 had a medical history of urinary retention. 10/24/16 - Hospital Discharge Summary with diagnoses that included urinary obstruction requiring catheterization. 10/24/16 - Admitted to the facility with an order for daily weights. 10/24/16 - Admission / Readmission Data Collection and Initial Plan of Care filled out by nursing staff on admission listed the indwelling catheter was being used for "neurogenic	F 514	A binder has been created to house the Activity Participation Logs for each current resident in the facility. An audit will be completed by the Unit Managers and/or designee ensuring that current pain assessments are current and include the resident's pain intensity goal. An audit will be completed by the MDS staff and/or designee ensuring that residents plan of care includes an Activity plan. Management staff will be in-serviced on the appropriate completion, review, organization and location of clinical record forms and assessment by the facility Administrator and/or designee. New pain assessments will be audited by the Unit Managers and/or designee weekly times four (4) to ensure assessments are complete and include pain intensity goals. A random audit will be completed by the Activity Staff weekly times four (4) weeks to ensure residents have a current Activity care plan in the plan of care. An audit will be completed weekly times four (4) then monthly times four (4) of medical records by the Medical Records Coordinator and/or designee to ensure clinical records are readily accessible and are systematically organized. The results of the audits regarding the clinical records will be discussed at the facility based QAPI meetings for the next	

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F 514	Continued From page 39 bladder." 10/25/16 - Post-Acute History and Physical documented urinary retention and that an indwelling catheter placed. 10/25/16 - Care plan for Urinary Catheter that noted "Neurogenic Bladder" as the reason. 10/25/16 - POS signed by the physician with urinary catheter orders with reason for use "neurogenic bladder" written in a different hand writing than the physician signature. 10/27/16 and 10/28/16 - no daily weights found. During an interview with E9 (MD) on 4/13/17 at 11:01 AM E9 stated that urinary retention and neurogenic bladder were noted the same and there was no evidence that R61 had a work-up done to diagnosis neurogenic bladder. 6. The following was reviewed in R78's clinical record: January 2017 - April 2017 - MD order for bruit and thrill monitoring of dialysis site. February 2017 - April 2017 - Review of TAR lacked an approach to monitor bruit and thrill. 4/11/17 at 2:33 PM - Interview with E2 (ADON) confirmed that the approach for monitoring was not on the TAR and s/he would add them. 4/11/17 at 3:02 PM - Interview with R78, who was alert and oriented revealed that nurses were monitoring the dialysis site.	F 514	three (3) months for additional recommendations and/or follow through.	

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F 514	Continued From page 40 7. Review of R112's clinical record revealed the following; 1/27/17 - A pain assessment sheet did not include R112's identified pain intensity goal. 2/21/17 - A pain assessment sheet did not include R112's identified pain intensity goal. During an interview on 4/12/17 at 9:34 AM with E2 (ADON) it was confirmed that the facility failed to document a pain goal for R112 on the pain assessment sheets. 8. Review of R147's clinical record revealed the following; 12/19/16 - A pain assessment sheet did not include the residents identified pain intensity goal. During an interview on 4/12/17 at 9:34 AM with E2 it was confirmed that the facility failed to document a pain goal for R147 on the pain assessment sheet. 9. Review of R19's care plan revealed there was no care plan for activities. During an interview with E3 (UM) on 4//11/17 at 1:00 PM E3 confirmed the care plan for activities was not in the care plan binder. E3 said s/he was "not sure when the last time the charts were thinned" and would check in medical records. Around 2:40 PM the same day (4/11/17) E3 informed the surveyor R19's care plan for activities had been thinned from the binder and was in medical records. E3 presented the care plan for activities to the surveyor for review before	F 514		

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F 514	Continued From page 41 being placed in the care plan binder. 10. Review of R43's care plan revealed there was no care plan for activities. During an interview with E3 (UM) on 4//11/17 at 1:00 PM E3 confirmed the care plan for activities was not in the care plan binder. E3 said s/he was "not sure when the last time the charts were thinned." and would check in medical records. On 4/12/17 around 11:00 AM E3 gave the surveyor R43's care plan for activities which was found in medical records. 11. During an interview with E19 (Activities Aide) on 4/10/17 at 1:00 PM, the surveyor requested to see the activity logs showing activities attended for three residents from the past three months. During an interview with E19 on 4/11/17 at 10:00 AM after not receiving the logs, E19 said "I don't know anything about them." E19 opened the drawer in the desk in the activity room and found logs from most of the months from 2016 and one from 2015. January 2017 and February 2017 were located. E19 was unable to locate March 2017. Surveyor needed to go through all the papers (one from each resident in the facility) in order to locate the desired ones. 12. Review of R177's clinical record revealed: January 2017 - Nursing progress notes documented R177 had hallucinations on January 4, 5, 6, 7, 8, 9. January 2017 - Behavior monitoring sheet recorded no hallucinations on January 4, 5, and	F 514		

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F 514	Continued From page 42 6. During an interview with E3 (UM) on 4/11/17 at 12:30 PM surveyor showed nursing note documentation of hallucinations yet the January 2017 behavior monitoring sheet did not accurately reflect the hallucinations. E3 confirmed the discrepancies and was going to try to locate the December 2016 behavior monitoring sheet in medical records. [The December 2016 behavior monitoring sheet was never located.] Cross refer F309 example #2: 13. Review of R184's clinical record revealed the following: 4/3/17 - Admitted to the facility after hospitalization for a kidney injury. 4/3/17 - Physician's admission orders included: weigh daily for 3 days. During an interview with E5 (RD) on 4/6/17 at 10:20 AM, the surveyor explained the inability to locate R184's daily weights. E5 stated that on the facility's admission data collection form, dated 4/3/17, a nurse documented that R184 weighed 78.4 lbs. Surveyor pointed out that R184 did not appear to weigh only 78.4 lbs, and that this facility weight conflicted with hospital documentation of 66 kg (145 lbs). E5 acknowledged this and stated s/he would follow up. During an interview on 4/13/17 at 10:15 AM, E5 stated the 4/5/17 weight (105 pounds) was found with the April monthly weights. E5 weighed R184 personally on 4/6/17 and the resident weighed 129 lbs. In addition, E5 reported that on 4/10/17 R184 weighed 131 lbs. E5 was unable to explain	F 514		

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F 514	Continued From page 43 the earlier discrepancies, but felt the last two weights (4/6/17 and 4/10/17) were accurate. E5 confirmed there was no weight for 4/4/17. These findings were reviewed with E1 (NHA) and E2 on 4/13/17 at 1:30 PM.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

ACILITY: New Castle Health and Rehabilitation

DATE SURVEY COMPLETED: April 13, 2017

	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from April 4, 2017 through April 13, 2017. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 103. The Stage 2 survey sample size was 35.		5/26/17
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on April 13, 2017: F167, F242, F272, F282, F309, F314, F315, F425, F428, F431, F441, F463, F514.	The plan of correction for the cross referenced deficiencies will be followed as outlined in the federal plan of correction	

Provider's Signature [signature] Title Administrator Date 5/7/17